Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

Respondent Name
INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-11-2220-01

MFDR Date Received
March 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI rule states that it is not enough for a carrier to file a TWCC denial code and that the carrier is required to submit claim specific language. Although the denial explanation is understandable it does not apply in this instance. The denial code and their description are too vague for our facility to determine the basis for the denial."

Amount in Dispute: $ 75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in carrier representative box number 19, assigned to Flahive, Ogden & Latson. On March 10, 2011 FOL FIleroom, Gordon Clayton picked up the DWC060 packet. An audit will be conducted based on the documentation contained in the file at the time of the review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2010	99372	$75.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out the guidelines for Medical Bill Submission by Health Care Provider.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97 – Payment is included in the allowance for another service/procedure

Issues

1. What is the definition of CPT code 99372?
2. Did the requestor include a correct billing code for CPT code 99372?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 99372 defined as "Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)."
2. Per 28 Texas Administrative Code §133.20 "(c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

   The requestor billed CPT code 99372 on July 20, 2010. The CPT code 99372 was deleted by Medicare on January 1, 2008 and replaced with CPT code range 99441-99443.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the dispute CPT code 99372 rendered on July 20, 2010.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 4, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.